Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13202

8 - OTHER

[redacted]

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[redacted]

Addressograph

DATA - HISTORY
SCREENING QUESTIONNAIRE

Date: 11/17/98 Time: 12:45pm

Allergy Sensitivity slip completed ☒ Yes ☐ No

Vital Signs:
Temp: 98.4 BP: 114/80 Pulse: 80 Resp: 16 Weight: 190 ☒ Stated ☐ Actual Height: 5'5" ☒ Stated ☐ Actual

Admitted from: Direct - ambulatory

Chief Complaint/Hx of Current Illness
abd pain 1 wk + 2 days. (R) Lower quad. - describes as labor pain - crampy

Source of information: ☒ Patient ☐ MD ☐ Family/S.O. ☐ Chart ☐ Other: Nausea last night

Patient/S.O Oriented to: ☒ Call Light ☒ Unit Routine ☒ Bathroom ☒ Patient Info. Handbook ☒ thanks

☒ Universal Precautions explained: If not, describe _____

☒ Patient/S.O. advised and states that any valuables kept in the hospital are at patient's own risk

☐ Valuables envelope completed by security ☐ Unable to advise patient/S.O.

Prosthesis ☐ Eye ☐ Leg ☐ Arm ☐ Implant/Joint _____ Other _____

Allergies ☒ None ☐ **Drug** ☐ **Food** ☐ **Latex** ☐ Tape ☐ Seasonal ☐ Animal

Allergy/Reac. _____ Allergy/Reac. _____

Allergy/Reac. _____ Allergy/Reac. _____

Have you had *ANYTHING* to eat or drink since midnight? ☒ Yes ☐ No

Have you ever had any form of anesthesia? ☐ Yes ☒ No

Please list surgeries and year:

When _____ What _____ When _____ What _____

When _____ What _____ When _____ What _____

When _____ What _____ When _____ What _____

Have you or any of your blood relatives ever had a problem with anesthesia? ☐ Yes ☒ No

If yes, explain _____

Do you smoke? ☒ Yes ☐ No If yes, how much? 1 pack How long? (age 14)

When was your last drink (ETOH)? _____ How much? _____ Frequency of use: occas. 6 wk 1 drink

Have your friends, family, co-workers ever been concerned about your drinking? ☐ Yes ☒ No

Do you currently use recreational drugs? ☐ Yes ☒ No

Do you have any dentures, dental caps, crowns, bridgework, or loose teeth? ☐ Yes ☒ No

If yes, explain _____

MEDICATIONS: Include Prescription and Nonprescription

NAME OF MEDICATION	DOSAGE	HOW OFTEN	LAST TAKEN
Tribiasi	QD.		yesterday 10pm -
Propacet	N-100mg.	prn. for pain.	yesterday 8A

PAST MEDICAL HISTOR

Have you ever had any problems with your health related to: (Check if yes, explain)

- ☐ Heart Disease: _____
- ☐ High/Low Blood Pressure: _____
- ☐ Artery/Vein Disease: _____
- ☐ Asthma: _____
- ☐ Resp/COPD: _____
- ☐ Cancer: _____
- ☐ Other: _____
- ☐ Liver Disease: _____
- ☐ Kidney Disease: _____
- ☐ Diabetes: _____
- ☐ TB: _____
- ☐ Neuromuscular Disease: _____
- ☐ Stroke: _____

Have you ever been hospitalized for non-surgical reasons? ☒ No

If yes, When _____ Why _____ When _____ Why _____

When _____ Why _____ When _____ Why _____

Do you have problems with your **bowels**? ☒ No

If yes, please check: ☐ Diarrhea ☐ Black stools ☐ Hemorrhoids ☐ Other _____

☐ Constipation ☐ Rectal Bleeding ☐ Ostomy

Do you have problems with **urination**? ☒ No

If yes, please check: ☐ Frequency ☐ Burning ☐ Other: _____

☐ Small/Large amounts ☐ Urgency

Do you have problems **sleeping**? ☒ No ☐ Yes ☐ Do you have sleep apnea? ☐ No ☐ Yes

Comments: _____

Do you have difficulty **reading/seeing**? ☒ No ☐ Yes Contacts/Glasses: ☐ No ☐ Yes ☐ With Patient

Do you have difficulty **hearing**? ☒ No ☐ Yes Hearing Aid? ☐ No ☐ Yes ☐ With Patient

ROLE/RELATIONSHIP PATTERN

Who do you live with? ☒ Spouse ☐ Family ☐ Alone ☐ Friend ☐ Other _____

Do we have your permission to speak with your family/S.O. about your care/treatment? ☒ Yes ☐ No

Support system (spokesperson) Name: Husband Phone Number: same

Who is able to help you with care at home? Name: see above Phone Number: _____

What is your current/previous occupation? _____

Do you have: **Advance Directive (AD)** ☐ Yes ☒ No

Living Will ☐ Yes ☐ Copy on Chart ☐ Requested copy ☐ No

Health Care Agent ☐ Yes ☐ Copy on Chart ☐ Requested copy ☐ No

* Durable Power of Attorney ☐ Yes ☐ Copy on Chart ☐ Requested copy ☐ No

* Conservatorship ☐ Yes ☐ Copy on Chart ☐ Requested copy ☐ No

Pt. interested in additional info. on AD ☐ Yes ☒ No Patient given booklet on AD ☐ Yes ☒ No

Within the past 1-2 years you used: * Home Care Services ☐ Yes ☒ No

* Meal Services ☐ Yes ☒ No

If yes to any of the (*) questions notify Clinical Resource Management (CRM) ☐ Yes CRM Notified

CULTURAL / SPIRITUAL

Do you have any religious, spiritual or cultural beliefs of which we need to be aware?
(i.e. food, dress, medication / treatment restrictions)

☒ No ☐ Yes List: _____

Do you have any special needs/considerations/expectations during your hospitalization of which we need to be aware?

☒ No ☐ Yes List: _____

Patient's primary language if other than English: _____ Understands English: ☐ Yes ☐ No

Translator Notified: ☐ No ☐ Yes Name: _____ Phone Number: _____

SIGNATURE OF NURSE: [redacted]

[redacted]

[redacted]

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PHYSICAL ASSESSMENT

[redacted]

Date: 11/17/98 Time: 12:45pm.

Vital Signs: Temp: 98.4 BP: 114/80 Pulse: 80 Resp: 16 ☐ See Data-History Form

Source of information: ☑ Patient ☐ MD ☐ Family/S.O. ☐ Chart ☐ Other: _____

SYSTEM	WITHIN DEFINED LIMITS EXCEPT

NEURO

☒ **WDL** A&O x 3, follows commands, speech clear, PERL, no visual field deficit, MAE, hands grasp equal, gait steady, absence of: numbness, tingling, swallowing difficulty

☐ Agitated ☐ Lethargic
☐ Obtunded ☐ Confused
☐ Weakness ☐ Combative
☐ Numbness ☐ Tingling

Handgrasp
☐ Unequal

Gait
☐ Unsteady

Pupil
☐ Sluggish
☐ No react
Note Size on GCS

☐ Unresponsive
☐ Speech Deficit
☐ Swallow Deficit
☐ Visual Deficit
☐ See GCS

☐ Any speech/swallow deficits identified, require discussion with MD for ST order

Comments: _____

RESPIRATORY

☒ **WDL**: Regular, Unlabored, Symmetrical, Breath sounds clear bilaterally

☐ Dyspnea ☐ Labored
☐ Orthopnea ☐ Wheezing
☐ Shallow ☐ Acc. Muscles
☐ Cyanotic ☐ Apneic

Cough
☐ Nonproduct.
☐ Productive

Lung Sounds:

☐ Diminished	☐ L	☐ R
☐ Absent	☐ L	☐ R
☐ Crackles	☐ L	☐ R
☐ Gurgles	☐ L	☐ R
☐ Wheeze	☐ L	☐ R

Comments: _____

CARDIOVASCULAR

☒ **WDL**: HR regular, peripheral pulses present bilaterally, no edema, refill <3sec.

Rhythm
☐ Irregular
☐ Arrhythmia
☐ Pacemaker

Chest Pain
☐ Scale 1-10 _____
☐ Radiation _____
☐ Duration _____
☐ Location _____

Pulses
☐ Diminished
☐ Absent
☐ Capillary Refill >3sec.

☐ Postural Hypotension
☐ JVD

Edema
☐ Non-pitting
☐ Pitting

Comments: _____

SYSTEM **WITHIN DEFINED LIMITS EXCEPT**

GI

☐ **WDL**: Abdomen soft, non-tender, bowel sounds active, no N/V, no diarrhea/constipation, Continent of stool

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☒ Distended ☐ Pain ☐ Rebound ☐ Rigid ☐ NPO ☐ Bowel Sounds

Last BM: 11/16 - diarrhea

Comments: _____

GU

☐ **WDL**: Voiding without difficulty, clear urine, no bladder distension, continent

☐ Frequency ☐ Dysuria ☐ Oliguria ☐ Hematuria ☐ Incontinent ☐ Distended ☐ Dialysis

Comments: _____

PSYCHOLOGICAL

☒ **WDL**: Calm and cooperative behavior, insight, and affect appropriate for situation

☐ Does not understand illness

Affect/ Mood:
☐ flat ☐ inappropriate ☐ labile ☐ tearful ☐ sad ☐ angry ☐ anxious ☐ restless

Behavior: ☐ inappropriate ☐ combative ☐ withdrawn ☐ sedated

Comments: _____

REPRODUCTIVE

☒ **WDL**: Regular menses, pre/post menopausal, no vaginal/penile discharge, no pain

LMP 10/20/98 -

☐ Irreg. Menses ☐ Pregnant ☐ Breast Feeding ☐ Vaginal Discharge ☐ Penile Discharge

Comments: _____

MUSCULOSKELETAL

☒ **WDL**: ROM of all joints, No muscle weakness or deformity

☐ Deformity ☐ Swelling ☐ Weakness ☐ Painful ROM ☐ Fracture

Comments: _____

PAIN

☒ **WDL**: No pain

Intensity of Pain Scale
0 = no pain - 10 = worst ever experienced

Level _____
☐ Acute ☐ Chronic ☐ Duration: _____

Location: _____
Frequency: _____ Constant Intermittent
Precipitating Factor: _____
Alleviating Factor: _____
Intensity 1-10 scale: _____
Current Treatment: _____
Effective: ☐ Yes ☐ No

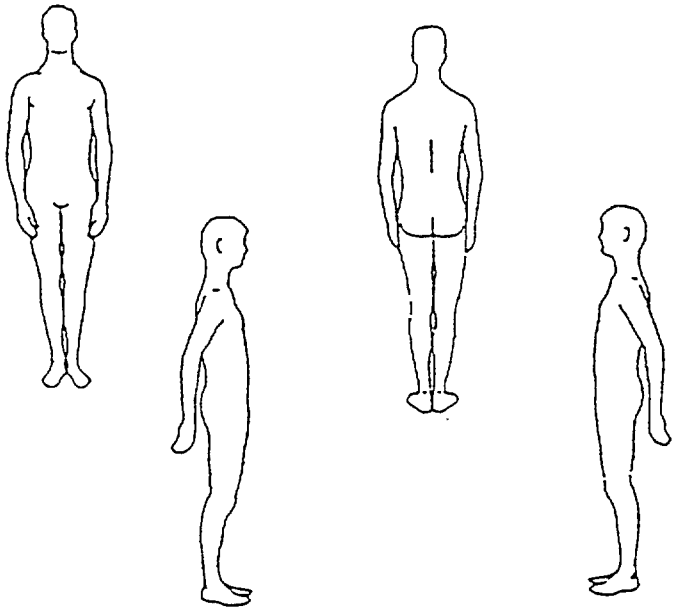
☐ **Narcotic Sedation Flow Sheet**
☐ **PCA Flow Sheet**
☐ **Epidural Flow Sheet**

☐ **Implemented**
☐ **In use**
Date: _____ **Time:** _____ **Initials:** _____

Comments: _____

SKIN

☒ **WDL**: Warm, dry, intact, turgor elastic. No redness or open areas.



Description of Stages
I - Erythema not resolving within thirty (30) minutes of pressure relief. Epidermis remains intact. REVERSIBLE WITH INTERVENTION.
II - Partial thickness loss of skin layers involving epidermis and possibly penetrating into but not through dermis. May present with erythema and/or induration; wound base moist and pink; painful; free of necrotic tissue.
III - Full-thickness tissue loss extending through dermis to involve subcutaneous tissue. Presents as shallow crater unless covered by eschar. May include necrotic tissue, undermining, sinus tract formation, exudate, and/or infection. Wound base is usually not painful.
IV - Deep tissue destruction extending through subcutaneous tissue to fascia and may involve muscle layers, joint, and/or bone. Presents as a deep crater. May include necrotic tissue, undermining, sinus tract formation, exudate, and/or infection. Wound base is usually not painful.

Skin turgor: ☐ Loose ☐ Tight

Identify skin condition on the body figure above.

I = Incision, R = Rash E = Ecchymosis, U = Ulceration, Red, L = Lesion, T = Tear, D = Decubitis, S = Scar, B = Burn

Pressure Sore ☐ Yes ☐ No Stage II and above

Implement pressure sore status tool for stage II and above: Date: _____ Time: _____ Initials: _____

PRESSURE ULCER ASSESSMENT

RISK ASSESSMENT		SCORE	SCORE OF 8 OR ABOVE - INITIATE PREVENTION		
General Physical Condition			Incontinence		
Good	0		None	0	
Fair	1	0	Occasional (less than 2 per 24hrs)	2	0
Poor	2		Usually (more than 2 per 24hrs)	4	
	3		Total (no control)	6	
Level of Consciousness			Nutrition (for age and size)		
Alert	0		Good	0	
Lethargic	2	0	Fair	1	1
Semi- comatose	4		Poor	2	
Comatose	6				
Activity			Mobility		
Ambulate without assistance	0		Full activity range	0	
Ambulate with assistance	2	0	Restricted movement	2	0
Chairfast	4		Moves only with assistance	4	
Bedfast	6		Immobility	6	

☐ Risk for development of pressure ulcer (include problem on care plan)

☐ Has existing pressure ulcers (see Pressure Sore Status Tool)

☒ Does not meet criteria for risk at this time

1

NUTRITIONAL RISK ASSESSMENT

☒ NO CURRENT RISK FACTORS

Weight: unintentional change >10lbs in 3 months
- ☐ Loss ☐ Gain

Special Diet Needs
- ☐ New onset Diabetes Mellitus
- ☐ Dialysis
- ☐ TPN/Tube Feeding
- ☐ Lactating/Pregnant

GI (prior to admission)
- ☐ Ability to eat/drink: consumes <50% of usual intake >3days
- ☐ Vomiting >3days
- ☐ Persistent difficulty swallowing or chewing
- ☐ Multiple food allergies or intolerances

(CALL IF ANY OF ABOVE CHECKED.)

Pressure Ulcer Assessment
- ☐ **Pressure Ulcer ≥ stage 2**

☐ **NUTRITIONAL REFERRAL INITIATED** (ext. [redacted])
Initials _____ Date _____ Time: _____

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FUNCTIONAL

☒ NO CURRENT FUNCTIONAL DEFICITS

- ☐ * Recent change in functional status
- ☐ * Difficulty walking
- ☐ * Fallen in the past six months

Uses an assistive device
- ☐ * Prosthesis
- ☐ * Walker
- ☐ * Crutches
- ☐ * Cane
- ☐ * Assist required bathing/dressing
- ☐ *Assist required eating/cooking
- ☐ * Assist required stairs
- ☐ * Assist required in transfers
- ☐ * Other _____

(*) **Requires discussion with MD for PT, OT order**

FALL PREVENTION ASSESSMENT

☒ NOT APPLICABLE AT THIS TIME

History of falls or trauma: ☐ Yes ☐ No
Impaired cognition (confusion, agitation, restlessness, poor memory): ☐ Yes ☐ No
Impaired mobility (plegias, vertigo, weakness): ☐ Yes ☐ No
Hypnotics, sedatives, or chemical restraints: ☐ Yes ☐ No
Impaired elimination (frequent urination or defecation): ☐ Yes ☐ No
Other: _____
If any Yes response above: **Institute the Safety Management Protocol:** ☐ Safety ☐ Restraint
☐ **Patient meets one or more of the above; however a safety issue is not applicable.**
A comment is Mandatory: _____

READINESS TO LEARN

Factors affecting Learning: ☐ Vision Impaired ☐ Hearing Impaired ☐ Speech Impaired
☐ Cultural/ Religious ☐ Cognitive
☐ Confusion ☐ Fatigue ☐ Anxiety ☐ Non-acceptance of disease

Is patient ready to learn? ☒ Yes ☐ No
If no, can Family/Significant Other be Taught? ☐ Yes Name: _____ ☐ No
Patient Education Record Implemented: **Date:** 11/17/98 **Time:** 12:45p **Initials:** [redacted]

Comments: _____

RN SIGNATURE [redacted]

[redacted]

INTERDISCIPLINARY PATIENT EDUCATION [redacted]raph

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Education Readiness	Yes	No	Comments/Explanations	Initials
Verbalizes willingness to learn	✓	*		
Understands reason for hospitalization	✓	*		

Factors Affecting Learning	Yes	No	Comments/Explanations	Initials
Physical	*			
Cognitive	*			
Emotional	*			
Cultural / Religious	*			
Language (Specify if other than English)	*			
Sensory / Hearing / Vision	*			
Other	*			

*** Requires comment**

Patient/Family/SO's perceptions of educational needs:

Changes in Factors Affecting Learning

Date	Time	Signature	Changes In

Considerations for Learning (e.g. financial resources, environmental, ability to read, interpreter, etc.)

Person(s) to be involved in Teaching:

Pt + Husband

Methods of Learning Preferred by Patient: (Explanation, Demonstration, Video, Handout)

INTERDISCIPLINARY PATIENT EDUCATION RECORD

* = COMMENT ON BACK

LEARNER	TEACHING METHODS	EVALUATION
P - Patient S - Spouse M - Mother F - Father O - Other - identify	E - Explanation D - Demonstration A/V - Audiovisual H - Handout	S - States understanding NR - Needs reinforcement D - Demonstrates skill independently DP - Demonstrate but requires physical or verbal assist N - No evidence of learning - comment required

Expected Outcome: The Learner is able to verbalize understanding of or demonstration	Learner (use key)	Teaching Method (use key) Resources Used/ Handouts Given	Evaluation (Use Key)	Date, Time, & Initials	Reinforcement Reevaluation Initials/Date	
1. ***Orientation to the Unit (visiting hours, Pt lounges, telephones, team members, information booklet)***						
a. unit [redacted]	P,S	E	S	11/17/98 [redacted]		
b. unit						
c. unit						
d. unit						
e. unit						
2. ***Disease Process or the Reason for Hospitalization***						
a. Treatment Plan	P,S	E	S	11/17/98 [redacted]	11/18 [redacted]	
b.						
c.						
d.						
e.						
3. ***Diagnostic Tests***						
a.						
b.						
c.						
d.						
4. ***Nutritional Education***						
a. low K+ low PO4 diet	P	E+H	S	11/18/98 [redacted]		
b.						
c.						
d.						
e.						
5. ***Medications (name, purpose, side effects)***						
a. food/drug interactions		Food & Drug Booklet				
b.						
c.						
d.						
e.						
f.						
g.						
h.						
i.						
6. ***Safe and Effective use of Medical Equipment/Special Procedures***						
a. coughing/deep breathing						
b.						
c.						
d.						
e.						
7. ***Activity***						
a. progression/restrictions						
b.						
c.						
d.						
e.						
8. ***Risk/Factor/Health Promotion***						
a. smoking cessation						
b. exercise						
c. stress management						
d.						
e.						

***** REMEMBER TO SIGN ON THE LAST PAGE *****

Expected Outcome: The Learner is able to verbalize understanding of or demonstration	Learner (use key)	Teaching Method (use ke Resources Used/ Handouts Given	Evaluation (Use Key)	Date, Time, & Initials	Reinforcement Reevaluation Initials/Date	
9. ***Discharge Plans/Community Resources***	P/S	E	S	[redacted] 11/18		
a. when and how to obtain further treatment						
b. agencies						
c. support groups						
d. _____						
e. _____						
10. ***Rehabilitation*** ☐ ***Yes***						
a. identify Functional Deficits						
b. Activities of Daily Living (ADL)						
c. mobility						
d. swallowing						
e. speech						
f. _____						
g. _____						
11.						
a.						
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*** REMEMBER TO SIGN ON THE LAST PAGE ***

INTERDISCIPLINAR TIENT EDUCATION RECORD PROGRESS FORM

DATE/TIME	COMMENTS

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SIGNATURE/TITLE	INITIALS	SIGNATURE/TITLE	INITIALS	SIGNATURE/TITLE	INITIALS
[redacted]		[redacted]			

[redacted] Revised: 7/98

[redacted]

Printed on 11/29/98 at 21:21:17

PATIENT NAME..... [redacted]
BILLING NUMBER.....
MEDICAL RECORD #....
ADMISSION DATE.....11/17/98
DISCHARGE DATE.....11/18/98
ATTENDING PHYSICIAN.. [redacted]
DISCHARGE STATUS.....AHR ALIVE, ROUTINE DISCHARGE

DRG.....316
RENAL FAILURE
MDC.....011
Diseases & Disorders Of The Kidney And Urinary Tract

ADMITTING DIAGNOSIS..584.9 ACUTE RENAL FAILURE NOS

PRINCIPAL DIAGNOSIS:
584.9 ACUTE RENAL FAILURE NOS
SECONDARY DIAGNOSIS:
588.1 NEPHROGEN DIABETES INSIP

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CODER: BC

[redacted]

DISCHARGE PLAN AND INSTRUCTIONS

Disposition: ☒ Home ☐ Home Health Agency ☐ Exte[redacted]
Agency/Facility (Name & Number): _____

Activity: ☒ As tolerated ☐ Limitations (specify) _____
Diet: ☐ Regular ☒ Other (specify) _____

Wound/Incisional Site Care/Treatments: _____

Equipment/Supplies: _____

Special Instructions: Don't take diet medications.

Preprinted Discharge Instructions given for: _____

MEDICATIONS

☐ **Resume all medications taken prior to hospitalization with the additions and exceptions noted below. If there are any questions about previous medications, please contact the prescribing physician when you return home.**

NAME/DOSE	SCHEDULE & SPECIAL INSTRUCTIONS	LAST DOSE TAKEN

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FOLLOW UP: Please call to schedule an appointment

DATE: 1 week MD Name: Dr [redacted] Phone #: [redacted]
DATE: _____ MD Name: _____ Phone #: _____
DATE: _____ MD Name: _____ Phone #: _____

I have read and understand the above discharge plan/instructions & have received a copy:

Patient/Representative Signature: [redacted] Date: _____
Nurse Signature: [redacted] Date: 11/12
Physician Signature Authorizing Discharge: [redacted] ID #: [redacted]

000013

[redacted]